

# Clear Resolutions Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** June/07/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Sacroiliac joint injection on left side

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO, Board Certified Physical Medicine and Rehabilitation

**REVIEW OUTCOME:** Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for the sacroiliac joint injection on left side has been established.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on XX/XX/XX while catching XX. The patient reported feeling a pop in the low back region. The patient had a prior surgical history for the lumbar region to include lumbar decompression and fusion completed in XXXX. The patient stated that she was doing well following surgery until the date of injury. Prior treatment had included three months of physical therapy with no relief. The patient reported short term relief with anti-inflammatories only. MRI studies of the lumbar spine from XX/XX/XX noted post-operative changes from L4 through S1 with no recurrent stenosis or evidence of instability. The patient was seen on XX/XX/XX with continuing complaints in the lumbar region. The patient's physical examination noted dorsiflexion weakness in the left lower extremity. Reflexes were 2+ and symmetric. No sensory loss was evident. There was a positive straight leg raise sign to the left. There was painful lumbar range of motion. There were positive provocative signs to the left consistent with sacroiliac joint dysfunction. The recommendation was for a sacroiliac joint injection. The requested injection was denied by utilization review on XX/XX/XX as there was lack of support in the current clinical literature for the procedure. The request was again denied on XX/XX/X due to the lack of support in the current clinical literature for the procedure.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The clinical records submitted for review note ongoing complaints of low back pain. The patient had positive provocative testing for left sided sacroiliac joint dysfunction. The patient has failed three months of conservative management to include physical therapy and the use of anti-inflammatories. No significant pathology on MRI studies of the lumbar spine were available for were noted. In this case it is reasonable to ascertain that the patient has developed sacroiliac joint irritation and pain due to the injury. The patient has failed a reasonable amount of conservative management and the only reasonable option at this time would be to proceed with a left sacroiliac joint injection. Although not currently supported by current currently supported by guidelines, this patient is a reasonable outlier due to failure of conservative management and positive

physical examination findings.

Therefore, it is this reviewer's opinion that medical necessity for the sacroiliac joint injection on left side has been established and the prior denials are overturned.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)